COVID-19 Vaccine Attestation Form

Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver Providers Participating in MassHealth: Non-Agency (Self-Employed) Providers

This form will help the ABI/MFP Waiver participant and/or their representative verify your vaccine status and make decisions about their safety and personal care, in accordance with 130 CMR 630.000. **Any non-agency (self-employed) provider who refuses to complete this form and/or comply with regulations promulgated, or orders issued, by the Department of Public Health pertaining to COVID-19 vaccination requirements will be subject to financial penalty by the MassHealth agency.**

By signing below, I acknowledge the following:

- I understand that non-agency (self-employed) providers working in the MassHealth ABI and MFP Waiver programs are required to complete the full required regimen of COVID-19 vaccine doses by October 31, 2021, per the Massachusetts Department of Public Health regulation 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization;
- I can produce proof of my vaccination status or proof supporting my need for a valid exemption;
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine, I may be at greater risk of contracting COVID-19 and/or spreading it to others; and
- **I understand that the ABI/MFP Waiver participant and/or their representative may choose not to have me provide ABI/MFP Waiver services based on this requirement**.

Non Agency (Self Employed) Provider Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full required regimen of COVID-19 vaccine doses. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine.

☐ I have requested a COVID 19 vaccine exemption based on one of the following (please check one):

- ☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination; or
- ☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief and have provided documentation to support this sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption.

Provider Name	Provider Signature	Date Signed
Waiver Participant Name	Waiver Participant Signature	Date Signed